# The Doctor-Patient Relationship and its Historical Context

Thomas S. Szasz, M. D., William F. Knoff, M. D., Marc H. Hollender, M. D.

Am J Psychiatry 1958 Dec;115(6):522-8. doi: 10.1176/ajp.115.6.522.

The doctor-patient relationship in its historical context depends on the medical (or psychiatric) situation and the social scene. By medical situation is meant the technical task at hand and the available means to cope with it. The physician's and patient's capacity for self-reflection and communication, as well as their special technical skills, are included in the category of "medical situation." The social scene refers to the socio-political and the intellectual-scientific climate of the time.

In a previous article, Szasz and Hollender (12) delineated three basic models of the doctor-patient relationship. These are (a) activity-passivity, (b) guidance-cooperation and (c) mutual participation. Activity-passivity refers to those instances in which the physician does something to a patient who is completely inactive (or passive). This is necessary whenever the patient is unconscious (e.g., comatose, anesthetized). Guidance-cooperation presupposes that the physician will tell the patient what to do and the latter will comply or obey. Both parties are "active" and contribute to the relationship. The main difference between them pertains to status and power. Mutual participation designates a relationship in which the doctor-patient contract is essentially that of a partnership. The physician helps the patient to help himself. This model is particularly applicable to the management of chronic illnesses, to psychoanalysis and to some modifications of psychoanalytic therapy. The models are illustrated in Table I.

Employing these conceptual models, we propose in this essay to present an historical overview of certain changes in the doctor-patient relationship. Since our interest is primarily in calling attention to correlations between social conditions and medical practice models, we shall comment only on a few historical periods. These will be offered as vignettes to illustrate our thesis. The following epochs and their concomitant doctor-patient patterns will be considered:

1. Ancient Egypt (approx. 4000 to 1000 B.C.).
2. Greek Enlightenment (approx. 600 to 100 B.C.).
3. Medieval Europe and the Inquisition (approx. 1200 to 1600 A.D.).
4. The French Revolution (late 18th century).
5. Central Europe (late 19th century).
6. The contemporary American scene (post World-War II).

## Ancient Egypt

From earliest times, man feared helplessness in an unknown universe. In his own defense he invented methods of coping with anxiety. Implicit in these methods has been man's belief in an ability to manipulate events, to control and direct nature in his own behalf.

The doctor-patient relationship, which evolved from the priest-supplicant relationship(2), retained the belief in an ability of a parent-figure to manipulate events on behalf of the patient. Fearing helplessness, sickness and death, man has attempted to master nature by means of 1. Magic and mysticism, 2. Theology and 3. Rationality (or science). Each of these evolving belief systems, with its particular technology, has served the healing art. Healers have been in the past (and continue to be in the present) magicians, priests and doctors. With the development of social organization, or civilization, the healing role became institutionalized as sorcerer, shaman, priest and physician. Each was imbued with the metaphor of magic. At various times, these diverse healing roles have existed side by side in the same society; they may also co-exist in the role-functions of a single individual (e.g., the shaman). As the functions of instinctive self-help and mutual aid were gradually institutionalized into specialized

**TABLE 1 ***

**Three Basic Models of the Physician-Patient Relationship**

| MODEL | PHYSICIAN'S ROLE | PATIENT'S ROLE | CLINICAL APPLICATION OF MODEL | PROTOTYPE OF MODEL |
|---|---|---|---|---|
| 1. ACTIVITY-PASSIVITY | DOES SOMETHING TO PATIENT | RECIPIENT (UNABLE TO RESPOND OR INERT) | ANESTHESIA, E.C.T., ACUTE TRAUMA, COMA, DELIRIUM, ETC. | PARENT-INFANT |
| 2. GUIDANCE-COOPERATION | TELLS PATIENT WHAT TO DO | COOPERATOR (OBEYS) | ACUTE INFECTIOUS PROCESSES, ETC. | PARENT-CHILD (ADOLESCENT) |
| 3. MUTUAL PARTICIPATION | HELPS PATIENT TO HELP HIMSELF | PARTICIPANT IN "PARTNERSHIP" (USES EXPERT HELP) | MOST CHRONIC ILLNESSES, PSYCHOANALYSIS, ETC. | ADULT-ADULT |

* A slightly altered version of a table which appeared originally in Szasz, T. S., and Hollender, M. H.: A Contribution to the Philosophy of Medicine. The Basic Models of the Doctor-Patient Relationship. A.M.A. Archives of Internal Medicine, 97: 585-592, 1956.

healer roles, status-role differences between healer and sufferer appeared for the first time.

Describing the treatment process, Sigerist stated: The magician came or the patient was brought to him. After some preparation, some purifications, the magic words were spoken, some rites were performed, and all was over. In many cases this was probably enough for the patient who was under great nervous tension to feel suddenly improved or even cured (6).

Even ancient Egyptian medicine, however, was not devoid of empirico-rational features. These were largely limited to the treatment of externally visible disorders, such as fractures. Problems

of "internal" medicine-like those of psychiatry-present certain observational difficulties in the face of a "naive" (culturally unsophisticated or childish) approach. Thus an infusion of magic in connection with these medical endeavors has persisted much longer than in relation to external and visible parts of the body. Even today, children-and people generally-have many more fantasies (and "fantastic" ideas) about the insides of their bodies than they do, for instance, about their hands or feet.

It seems unlikely-and this is largely an assumption, since we possess little information on this subject-that in ancient Egyptian medicine the activity-passivity type of relationship was ever altered. Neither the social circumstances nor the technical tasks and tools available were such as to require a modification of this relationship.

**Greek Enlightenment**

As Zilboorg noted, "Hippocrates lived in an age unique in history… It was the age of Hellenic enlightenment"(13).

In about the fifth century, B.C., the Greeks developed a system of medicine based on an empirico-rational approach. By this it is meant that they relied increasingly on naturalistic observation, supplemented by practical trial and error experience, abandoning, as much as they could(2) magical and religious explanations of bodily disorders. Singer, for example, described the Hippocratic writers as clear-eyed observers, unmoved in their pursuit of truth by any preconceived view of its nature, uncorrupted by the jargon of the schools, naked heroes of science facing the world as it is and not as it may be thought to be(7).

Hippocrates' rationalistic orientation can be best illustrated by the famous statement attributed to him concerning epilepsy: As for this disease called divine, surely it too has its nature and causes whence it orginates, just like other diseases, and is curable by means comparable to their cure (7).

In carrying empirical medicine to new heights, the Greeks were among the first to emphasize and develop what has become an historically important schism, namely, the separation of medicine (and science) from religion (and ethics). Politically, too, they were among the first nations to evolve toward a democratic form of social organization. They recognized the desirability of equality, at least among the elect (i.e., among the nobility or "non-slaves"). Guidance-cooperation, and to a lesser extent, mutual participation, were the characteristic patterns of the doctor-patient relationship. The Hippocratic oath, while overfly a code of ethics for the physician, is, in a less obvious sense, also a "Bill of Rights" for the patient. The rules of the game (as it were), codifying the physician's prescribed attitude toward his patient, were defined, in part, as follows:

> The regimen I adopt shall be for the benefit of my patients according to my ability and judgment, and not for their hurt or for any wrong … Whatsoever house I enter, there will I go for the benefit of the sick, refraining from all wrongdoing or corruption, and especially from any act of seduction, of male or female, of bond or free. Whatsoever things I see or

> hear concerning the life of men, in my attendance on the sick or even apart therefrom, which ought not to be noised abroad, I will keep silence thereon, counting such things to be as sacred secrets.(8) (italics added).

This oath is of considerable interest from the point of view of the doctor-patient relationship and its connections with the prevalent socio-political pattern of its time. Not only does the Oath reflect the contemporary ethical ideal of democracy for -and equality among- the free citizens of the state, but it rises above it and commands a higher level of humanism. We base this inference on the Hippocratic injunction to accord the same human privileges to the "bonded" patient, for slave, as accorded to free citizens of the state. Hippocratic tradition raised medical ethics above the self-interests of class and, by implication, nation. This supranational concept of health as an ethical value persists to this day, but it has undergone important reverses during practically every major war and social upheaval.

**Medieval Europe and the Inquisition**

The revival of religious and mystical world views following the fall of the Roman Empire, and culminating in the Crusades and witch-hunts of the middle ages, brought with it a regression in both political and medical relationships. A major historical event worthy of special mention occurred in 1484, when Pope Innocent VIII issued a papal bull in support of the popular medieval belief in witches.

The Inquisition now shifted into high gear. Two inquisitional theologians, Sprenger and Kraemer, authored that medieval textbook of clinical psychiatry entitled *Malleus Maleficarum* — *The Witches' Hammer* — which fanned a smouldering demonology into a flame which engulfed Europe and eventually spread to the shores of the New World.8 In regard to this period, Zilboorg observed:

Galen's humoral theory is pushed into the background and the devil is elevated [again] to the role of causative agent of melancholy. Sin and mental disease have become equated in the mind of man; the major sin of man and woman and the major preoccupation of the devil is sex(13).

Thus the primitive, magico-religious beliefs embodied in the Old and New Testaments were revitalized and charged with power. Social relations, too, drifted towards ever-increasing depths of inequality and exploitation. While feudal monarchies dominated the political scene, medieval Catholicism rose to achieve a level of secular power unmatched in its history. The political dominance of feudal royalty was paralleled by the moral dominance of contemporary religion. The divine right of kings had as its corollary the subjugation of the masses. Magic, mysticism and superstition were rampart. Good and evil were God-given and sharply and indelibly etched. (Although Massachusetts reversed most of its witchcraft convictions in 1711, it was as recently as August, 1957 that the names of 6 women, executed in Salem, and branded as witches for 265 years, were cleared by legislative resolve.) This was the tenor of the time. As would be expected, medicine and religion were inextricably entwined. The physician, imbued with magical powers shared by the priests, was in an exalted position. His patient, unless of the

nobility, was regarded as a helpless infant. The model of the doctor-patient relationship, like that of lord-serf, was activity-passivity.

Mental disorders, too, it should be noted, were regarded in the religious frame of reference. People were, so to speak, either possessed by God, and therefore saints, or possessed by the Devil, and hence witches. Neither fell within a category which could be called "medical" or "psychiatric."

It is interesting to note, in this connection, that while in our time there has been a widespread desire to exonerate, as it were, the witches either as innocent victims of their time, or as "mentally ill" rather than "bewitched," there has been no similar clamor for revising the diagnostic category of "saint" (e.g., Joan of Arc). Yet it would seem that if logic rather than sentimentality governs the upgrading of "witches" to "patients," an analogous downgrading of "saints" to "patients" would follow(10).

It is consistent with the "human atmosphere" sketched above that it was during this period that the insane asylums, which were nothing but dungeons in which mental patients were chained until they died, came into being. Such were the historical-and from the point of view of the evolution of man's struggle for freedom, logical-antecedents of the French Revolution.

**The French Revolution**

The spirit of liberalism initiated by the Renaissance, fostered by nascent Protestantism and brought to a high pitch by the French Revolution re-animated man's search for equality, dignity and empirical science as opposed to dogma. The successful Protestant "protest" — the original meaning of this word is probably rarely remembered now-against the unopposed might of the Roman Catholic Church was followed by America's successful overthrow of English dominance, and then by that momentous social upheaval, the French Revolution.

There are striking illustrations of the effects of the dominant socio-political events on medical behavior during this period. As we noted, the pre-revolutionary dungeon which served as a mental hospital was the appropriate place of confinement for socially undesirable elements in a society which viewed life and the deviant people in it only in two colors: black and white-witch and saint. The French Revolution-and the events which led to it brought this period to a socio-political end. Pinel's effort to free mental patients was equally dramatic, but it would seem, much less effective. Today, we look upon the "open hospital" and so-called milieutherapy as if they constituted modern dynamic-psychiatric innovations. Yet, their relevance seems to lie mainly in that mental patients were until recently-and are today still-locked up (committed) (11). Relieving them from this social and iatrogenic trauma may then seem like a form of "therapy." How different is this phenomenon from the well-known witticism about the man beating his head against the wall, because-as he said-it felt so good when he stopped it?

The effect of Pinel's efforts, however, should not be minimized. Certainly the status of the patient and the attitude of the physician were altered. The model of this relationship, accordingly, changed (although not completely) from activity-passivity to guidance-cooperation.

It should be recalled that more than 200 years earlier, Weyer had advocated reforms in the treatment of the "insane." His pleas, however, fell on deaf ears. He was, so to speak, ahead of his time. By this it is meant that he advocated an altered doctor-patient relationship which was premature in terms of the social scene.

**Late Nineteenth Century Central Europe**

The rapid growth of science during the 18th and 19th centuries led to the development of the physician as the expert engineer of the body as a machine. This state of affairs favored, as we know, developments principally in microbiology and surgery. Concurrently, patterns of the doctor-patient relationship stressed the latter's dependency and inferiority. In medicine proper, the development of anesthesia stimulated progress in surgery. The main non-surgical illnesses of the time were, of course, syphilis, tuberculosis and typhoid fever. In treatment, the activity-passivity, or at most the guidance-cooperation, type of doctor-patient relationship prevailed.

In the late 19th century two major psychiatric trends developed. One was the Kraepelinian, or "organic" approach; the other, originated by Breuer and Freud, was the psychoanalytic-and in a broad, contemporary sense, the psycho-social approach. Both, as we well know, are still very much with us and constitute, in fact, the principal conceptual and methodological viewpoints of present-day psychiatrists.

Commenting on this phase of psychiatric history, Szasz stated:

> Kraepelin's chief objects of observation were inmates of mental hospitals[4]. He studied them by direct common-sense observation. The underlying assumption was first that they suffered from diseases much the same as other diseases with which physicians were familiar, and second that society and the physicians who studied them were "normal" and constituted the standards with which their behavior was compared. Accordingly, patients were subsumed under categories ("diagnoses") based on the behavioral phenomena ("symptoms") that were judged to be dominant. The spirit of the inquiry precluded emphasis on specifically individualistic features and determinants; Kraepelin's approach, as Zilboorg [13] noted, was therefore at once humane and inhuman. He was interested in man, but was not interested in the patient as an individual (9).

The Kraepelinian or "organic" approach to psychiatry thus rests on the premise that the patient "has"-in the sense that he "possesses" something-a "disease." The eradication of the disease is thus pictured on the model of ridding the body of pathogenic bacteria. In a way this is a scientifically updated analogue of exorcising the devil(5). Adherence to this orientation predisposes to continued espousal of the activity-passivity or the guidance-cooperation models as the appropriate types of doctor-patient relationships in psychiatric treatment.

From the standpoint of our present interest, one of the most significant features of Breuer's psychological discoveries lies in the great attention which he was able to pay to his patient as a human being. In terms of the doctor-patient relationship, the cathartic method meant that it was worth while to listen to the patient at great length. While this may seem like a minor point

today, it should be remembered that the listening role, extended over a period of time, was a radical departure in the medical and psychiatric practice of the 19th century.

Breuer's personal qualities and interests made it possible for him to develop what must be judged as the first genuinely communicative relationship (in a medical setting) between doctor and patient. As a result of it, as Breuer reported, the patient's "… life became known to me to an extent to which one person's life is seldom known to another…"(1).

Breuer's relationship with his patients must, for proper emphasis, be contrasted with that of Charcot. Charcot, no doubt, may have divined some of his patients' secrets such as unfulfilled (sexual) longings. We submit, however, that he never knew his patients in the sense in which Breuer and Freud came to know theirs. Accordingly, Breuer and Freud's historical role lies (among others) in having reintroduced, as it were, the patient into the medical arena as an active, cooperative-and indeed, collaborative-participant in illness and in health. The early cathartic method opened the way not only to the psychoanalytic method but-from the point of view of the doctor-patient relationship-also to the development and broad implementation of the model of mutual participation.

It is apparent that while in the Kraepelinian viewpoint "mental diseases" are regarded as entities located in the patient's body, and usually in his brain, according to the psychoanalytic approach — as it is generally understood today — the same phenomena are considered as problems or conflicts in human relationships. The full effect of these divergent views on the nature of the doctor-patient relationship has been appreciated only recently.

There is the danger of over-psychologizing Breuer and Freud's early ideas concerning the nature of their own work. It seems to us that while they were well aware of the "human problems," so to speak, with which they dealt, they nevertheless continued to formulate their work in the traditional theoretical framework of their time (i.e., "disease-and-health"). The alleged diseases simply were regarded as belonging to a special group, namely those due to the damming up of libido. Moreover, according to Strachey, To the end of his life, Freud continued to adhere to the chemical aetiology of the "actual" neuroses and to believe that a physical basis for all mental phenomena might ultimately be found(1).

**The Contemporary American Scene**

The development of our current ideas and practices, both in medicine and in psychiatry, reflect the influences of 3 main factors: 1. From psychoanalysis specifically, and more generally from modern American psychiatry (Meyer, Sullivan), stems an increasing appreciation of the importance of the patient's role as that of a self-determinate partner in the therapeutic relationship. 2. Increasing medical and social emphasis on chronic illnesses (e.g., diabetes, arthritis, cardio-renal diseases, etc.) during the first half of this century made it necessary for physicians to enlist their patients' collaboration as medical assistants, as it were, in the management of their own health problems.4 Since "complete cure" is not a meaningful concept in most of these medical situations, it is for technical reasons usually impossible for the physician to rely on active-passive techniques. The guidance-cooperation model is therefore

feasible but falls short of being desirable. 3. The steady drift in social relations (in America as well as in most parts of the world) toward increasing acceptance of, and often insistence on, "democratic" or "socialistic" (equalitarian) patterns of behavior exerts -— we assume — a (4 In this connection it is interesting to recall the Hippocratic aphorism, "Life is short, art is long, opportunity fugitive, experimenting dangerous, reasoning difficult: it is necessary not only to do oneself what is right, but also to be seconded by the patient, by those who attend him, by external circumstances" (3, p. 96; italics added)). pressure on medical relations to conform to a similar pattern, whenever possible.

In (non-psychiatric) medicine, all these factors tend to favor the increasing utilization of mutual participation in the doctor-patient relationship. At the same time, the doctor is involved, probably more often than ever before, in the task of educating his patient in matters of health, illness or treatment.

In psychoanalysis and psycho-socially oriented psychiatry, the same factors have led to two major developments. One is the relatively widespread acceptance of, indeed demand for, psychotherapy. Thus, the social and economic success of psychoanalysis, which has been greater in the United States than in any other country, probably has resulted — as has been suggested by others too — from the political and socio-economic climate of this country. The second development, in which psychoanalysis again has pointed the way, is the need in many situations for both doctor and patient to scrutinize the very relationship in which they are engaged. Freud's fundamental concept of "transference" was the first step in this direction. Inquiry along this line received great impetus, however, also from the work and findings of sociologists and cultural anthropologists.

All this is not to say that the psychoanalytic method of treatment rests wholly on, or employs only, the model of mutual participation. There is controversy over certain important variables in this regard, for example concerning how much regression is fostered by the analyst in the analytic situation. Since we are not concerned now with a discussion of the precise details of a particular mode of psychiatric or medical treatment, it should suffice to note that the scrutiny of diverse therapeutic interactions in terms of their characteristic doctor-patient relationships would constitute an important means of clarifying dissimilar operations, now subsumed by a single name (e.g., "psychotherapy").

**Summary**

The doctor-patient relationship which characterizes a given situation depends on two principal categories of variables: the medical situation and the social scene. The cultural matrix impinges on the individual characteristics of both physician and patient in the form of learned orientations to disease, treatment, cure and to the doctor-patient relationship itself.

We have briefly reviewed and commented on the probable connections between the socio-historical and intellectual-scientific circumstances of 6 historical epochs and the prevalent type(s) of doctor-patient relationship.

It is our thesis that the value of a specific pattern of the doctor-patient relationship can be established only by evaluating all the relevant and pertinent variables. We would suggest, however, that awareness of the cultural relativity of the doctor-patient relationship should make us skeptical of the assumption that our current practices are "good" or the "best possible." Probably more often than not, they are neither, but simply reflect the congruence of social expectations and socially shared ethical orientations of physicians. In this connection, physicians, and perhaps psychiatrists particularly, explicitly may consider which of the following 3 alternatives they favor: 1. That they reflect the prevalent social values and expectations of their culture; 2. That they lag behind the social changes of the time and represent the values of the immediate past; or 3. That they join with those forces in society which lead to its modification (whether to "progress" or "regress"). Critical examination of the doctor-patient relationship usually predisposes to change, while non- scrutiny of human social relations favors the status quo.

*Read at the 114th annual meeting of The American Psychiatric Association, San Francisco, Calif., May 12-16, 1958.*

**Bibliography**

1. Breuer, J., and Freud, S.: Studies on Hysteria (1893-95), in The Standard Edition of the Complete Psychological Works of Sigmund Freud. London: Hogarth Press, Ltd., 1955, Vol. II.
2. Edelstein, Ludwig: Bull. Hist. Med. 5: 201, 1937.
3. Anon. Aphorism. Encyc. Britann. 2: 96.
4. Kraepelin, E.: Manic-Depressive Insanity and Paranoia. Edinburgh: E. and S. Livingstone, 1921.
5. Reider, N.: Am. J. Psychiat., 111: 851, 1955.
6. Sigerist, H. E.: A History of Medicine, Vol. I, New York: Oxford University Press, 1951.
7. Singer, C.: Hippocrates and the Hippocratic Collection. Encyc. Britann. 11 :583.
8. Singer, C.: Medicine, History of. Encyc. Britann. 15: 196.
9. Szasz, T. S.: Am. J. Psychiat. 114: 405, 1957.
10. Szasz, T; S.: A.M.A. Arch. Neurol. and Psychiat., 76: 432, 1956.
11. Szasz, T. S.: J. Nerv. and Ment. Dis., 125: 293, 1957.
12. Szasz, T. S., and Hollender, M. H.: A.M.A. Archives of Internal Medicine, 97: 585, 1958.
13. Zilboorg, G.: A History of Medical Psychology, New York: W. W. Norton and Co., Inc., 1941.

*Inaccuracies have been introduced by third-party scanning. For accuracy consult the original publication.*